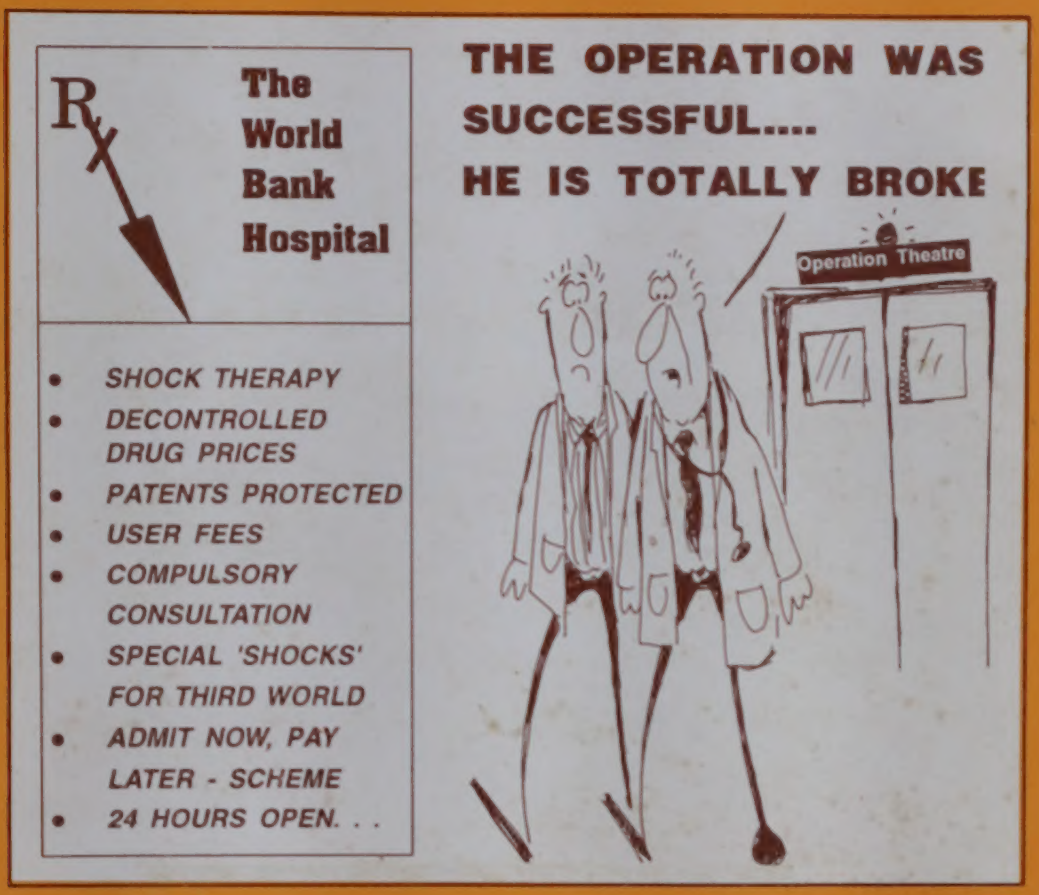
UNHEALTHY TRENDS



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The World Bank, Structural Adjustment and the Health Sector in India

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PUBLIC INTEREST RESEARCH GROUP

Unhealthy Trends : The World Bank, Structural Adjustment and the Health Sector in India

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Contents

Glossary

IMR : **Infant Mortality Rate refer to the number of infants who die, per thousands live births.**

MMR : **Method Mortality Rate refers to the number of women who die due to child birth related causes, per ten thousand live births.**

NRR : **Net Reproduction Rate refers to the number of female children produced by every woman (This has implications for population growth).**

DALY : **Disability Adjusted Life Years, a relatively recent concept, is a measure that combines healthy life years lost because of preventive mortality, with those lost as a result of disability.**

WDR : **World Development Report—a document report prepared annually by the World Bank.**

HDR : **Human Development Report—a document compiled annually by the United Nations Development Programme (UNDP).**

WHO : **World Health Organisation.**

FAO : **Food and Agriculture Organisation.**

The Context

The decade of the 80s will be remembered as the decade of global impoverishment linked to the World Bank (WB) and International Monetary Fund (IMF) economic medicine: the Structural Adjustment Programme (SAP). Since then, the adjustment programmes have aggravated the problem of impoverishment of millions of people in nearly 100 countries. These programmes have been imposed on developing countries as a condition for the renegotiation of their external debt.

The consequences of the adjustment programmes, which include collapse of health and education systems, eruption of mass famine and hunger, collapse of internal purchasing power and increase in unemployment, has been well documented. Although the WB-IMF have also acknowledged "the social impact of adjustment", no shift in the policy direction of these institutions has taken place. In fact, more and more countries are being administered the same remedy. Since late 1980s, this economic medicine has been imposed on Eastern Europe, Yugoslavia and the former Soviet Union, with devastating economic and social consequences. Despite global adjustment, the third world's debt burden rose from $ 785 billion in 1978 to $ 1.6 trillion in 1992. The structural adjustment loans from the Bank have enabled the third world countries to make interest payment to western commercial banks. Having done this, the Bank went on applying adjustment programmes to assure a regular supply of repayments.

Although the Bank has acknowledged "the social impact of adjustment", yet no shift in its policy direction has taken place.

Adjusting the Health Sector

Since 1991, India has been implementing the SAP under the direct supervision of the WB-IMF in order to repay India's debt. Although this period of three years (1991-94) is not sufficient to evaluate the overall impacts of the adjustment programme, yet this period clearly indicates the nature and direction of the economic reforms, as well as the adverse consequences on various sectors of the economy. Perhaps, one of the more visible and direct impacts of the adjustment programme in India has been on the social sectors, especially health, education and social security.

Unlike industry and agriculture, the sectors of health and education do not enjoy the support of any strong political lobby in India. Therefore, these sectors are facing the real burden of adjustment programmes. The recent figures show that our total external debt now is Rs 2760 billion. By the end of March 1993,

Year	External Debt (Rs. billion)	Debt Service (Rs. billion)	Expenditure on Health & Family Welfare (Rs. billion)
1989-90	1350.0	136.8	3.48
1990-91	1511.2	146.3	3.97
1991-92	2559.9	246.6	4.50
1992-93	2702.7	245.1	5.59

Source : Economic Survey, 1993-94

the total external debt was Rs 2700 billion with an annual debt repayment of Rs 210 billion. A comparison of India's external debt and health expenditure since 1980s reveals interesting trends and linkages. Since the 1980s India's debt has been rising rapidly whereas expenditure on the health sector has been declining in real terms.

Our external debt was only Rs 300 billion at the end of December 1980. This increased to Rs. 2702 billion in 1993 - an increase of over 900%. In rupee terms, the burden of debt has mounted, thanks to devaluation, from Rs. 1.5 lakh crore in 1991 to Rs. 2.70 lakh crore by March 1993—an increase of nearly 100% in just two years.

Nevertheless, there is no denying the fact that a number of loans and aid packages were approved by the World Bank and other bilateral agencies for the health sector in the 1980s and early 1990s. A close look at the Bank's financed projects in India on population, nutrition, child survival and safe motherhood, family welfare, leprosy eradication and other projects will support this argument.

Therefore, one would expect that these loans would have increased the outlay for health services. But, the reverse has actually happened. The share of health expenditure in total expenditure (for Centre and States combined) has been declining since the mid-1980s. The recent pronouncements by the Prime Minister, Mr. Narsimha Rao that the Government's invitation to transnational corporations (TNCs) in the power sector is meant to divert Government's investments from power sector to social sectors, carries less weight for two major reasons. Firstly, over the years, the Governement is borrowing heavily from Bank and other donor agencies for social sectors, especially health and education. After the implementation of the adjustment programme, these borrowings for social sectors have increased tremendously. In fact, the over-reliance on foreign funds for social sectors has already led to certain structural charges in these sectors and made these quite vulnerable to external pressures. The commodification and commercialisation of health services in India

Since the 1980s India's debt has been rising rapidly, whereas expenditure on the health sector has been declining.

can be attributed, to a large extent, to this pressure. Secondly, the TNCs involved in power generation will produce power at a higher price. With a 16 percent post-tax return in dollar terms, counter guarantee by the State Governments who will buy power from TNCs, and counter guarantee by the Central Government, the exchequer of State Electricity Boards (SEB) managed by the States will increase. Unable to raise power tariffs and recovery of dues for various political reasons, the State Governments will not be able to raise enough resources to pay TNCs. Thus, the funds meant for social sectors especially health and education will be slashed and diverted to fill the deficit in the power sector.

What is disturbing is the fact that recommendations for the health sector are not derived from any epidemiological data about the real needs of the people, but from a financial institution whose mandate, as envisaged in its Article of Agreement, is to stabilise major exchange rates and reconstruction of economies. Moreover, the Bank has no competence and experience to lay out blue prints for health services. One wonders how many qualified health experts or doctors are employed at the Bank.

Central Govt Plan Outlay
[Medical and Public Health]

Year	Plan outlay (Rs million)	Index (at constant prices 1980-81=100)
1989-90	1157	100.0
1990-91	1134	98.0
1991-92	1104	95.4
1992-93	1593	134.0

Source : Union Budget, different years.

It is in this context that one should see the Public Expenditure Reviews (PER) by the World Bank. Under PER, the Bank not only asks for cuts in expenditure in the health sector but also gives detailed instructions for cuts in specified areas such as primary health care.

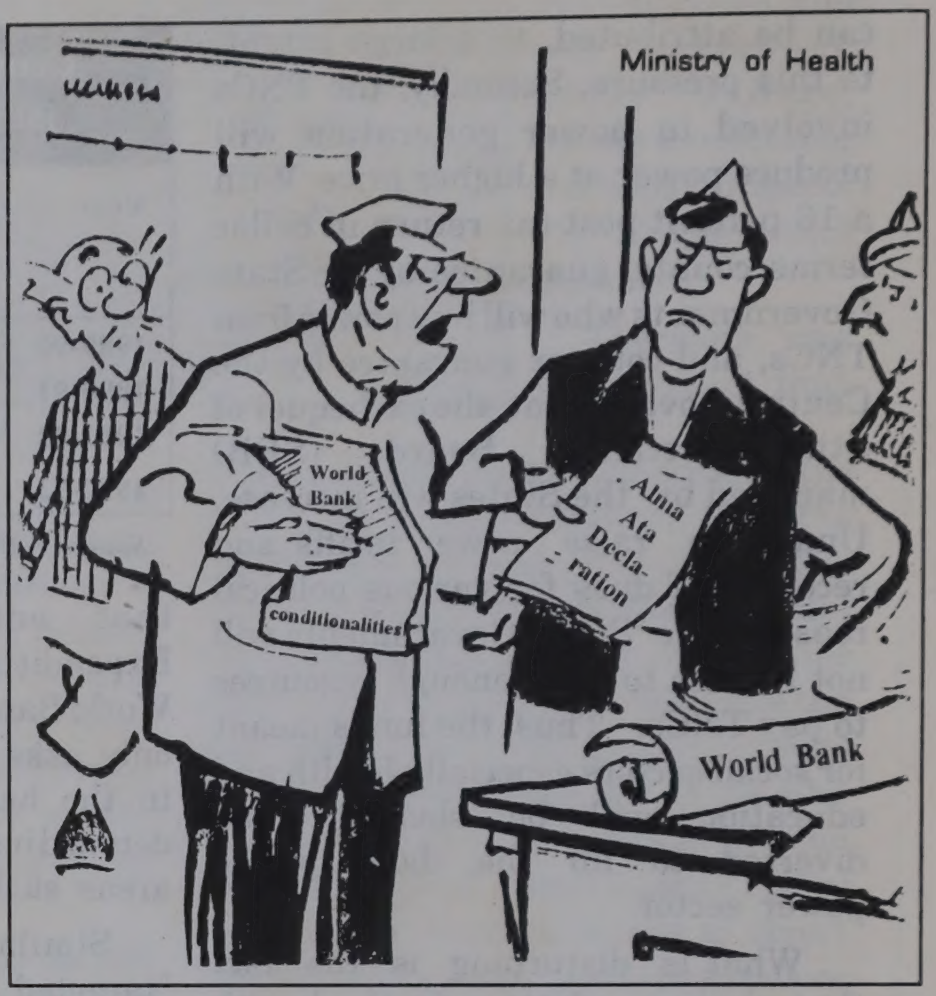
Similarly, the Bank's so-called "targeted programmes" for health care which are combined with cost recovery, privatisation, and withdrawal of the State from health services, have failed to help the poor, who do not have any purchasing power to enter into Market to buy health services like any other commodity.

The Bank has no competence and experience to lay out blue prints for health services. One wonders how many qualified health experts or doctors are employed at the Bank.

The latest report on the health sector by the World Bank entitled "Investing in Health" suggests that public expenditure on health should be reduced, and existing expenditure be reallocated. It is very well documented that limited and selective health services (such as

in the U.S.) are not successful anywhere in the world.

To implement target-oriented programmes, the Bank has launched Social Emergency Fund (SEF). The creation of SEF in Bolivia and Ghana by the World Bank clearly demonstrates that a separate and parallel organisational structure is created, and non-governmental organisations (NGOs) begin to take over many of functions such as schools, health services and sewage clearance. These functions were earlier carried out by the local governments whose funds have been frozen as a result of the adjustment programme. Such a "human face" approach is supposed to help in the "management" of poverty, social unrest and tension while the resulting savings from the cuts in social sectors are channelised towards the repayment of debt to the Bank, IMF and other creditors.



Who told you to bring the Alma Ata Declaration? Go and sell it as waste paper because Government needs resources to fill the fiscal deficit!

Illustration Courtesy : Laxman/Times of India

Under the Alma Ata Declaration, India is committed to Health for All by 2000 A.D. Unfortunately, the present trend of external debt and its repayment shows that India's debt and its repayment is increasing day by day. As the recent Reserve Bank of India Report points out, "Repayment to the IMF towards withdrawals under the Compensatory and Contingency Financing and Standby Arrangement would be large during the 1994-95 to 1996-97 with a peak in 1995-96" This current trend also shows that the Indian Government has preferred to remain committed to the Bretton Woods System, thereby nullifying its commitment to the Alma Ata Declaration. ■

Unfortunately, the Indian Government has preferred to remain committed to the Bretton Woods System thereby nullifying its commitment to the Alma Ata Declaration.

The State of India's Health Sector

The British in India were responsible for initiating an institutionalised health care delivery system—not for the public at large but to serve the needs of British armed forces and civilian administrators. With the advent of provincial governments, subsequent to the Government of India Act 1919, some semblance of a medical care network evolved. By 1941, 2,150 hospitals and 5,291 dispensaries were in existence, 74% of which were in rural areas.

New Proposals

The Bhore Committee was set up to evolve a comprehensive health care plan for independent India. In 1946, the committee put forth a plan that was almost equivalent to Britain's National Health Service, but also incorporated features of the Russian Health System. The philosophy underlying the proposed policy was that no individual should fail to secure adequate medical care due to inability to pay. There was an emphasis on preventive aspects of health care, and the plan envisaged the active involvement of people, rather than an alienating set up. The Bhore Committee advocated setting up a tiered system of health care services which would provide medical help using resources in the best possible way. Each district was to be divided into 'primary units' corresponding to a 'block', which would have a Primary Health Centre (PHC) to provide curative as well as preventive services. Patients needing more specialised care were to be referred to a 'secondary unit' which would have hospital facilities for 200 beds along with the necessary staff. The committee clearly pointed to the necessity to prioritise rural areas; since an agricultural economy rested on the well being and productivity of the rural population.

The Reality

However, after Independence, the Bhore Committee Report remained unimplemented, owing to the direction of India's economic policy to serve the needs of private capital. Consequently, State investment was biased in favour of heavy industry and economic infrastructure with the understanding that such participation by the State in economic production would evolve a socialist society. As a result, the 'welfare' sector—health, education, social security etc was not considered a priority for State investment.

After Independence, the Bhore Committee Report remained unimplemented, owing to the direction of India's economic policy to serve the needs of private capital.

Even within the low health budget, the resources were used to benefit industrial workers—the section

Table 1

Growth of Health Infrastructure in India

	1941	1951	1961	1971	1981	1988
Hospitals						
Total	2,150	2,694	3,334	3,862	6,805	9,831
Rural	—	—	1,131	—	1,821	3,099
PHCs	—	—	2,565	5,112	5,740	14,609
Doctors *(allopaths)*	47,524	61,440	83,756	151,129	268,712	342,740
Nurses	7,000	16,550	35,584	80,620	154,230	229,850

Source: Compiled from several official documents.

considered of utmost importance to the national economy. For instance, one of the first health measures that the newly appointed government carried out was the Employees State Insurance Act 1948, which provided for medical benefits for industrial employees. It is worth noting that this measure was implemented for a group of workers who formed a small minority of the total Indian workforce. It, however, took the government five years after independence to formally set up the first Primary Health Centre, although the primary health centre experiment was made in several places in India long before independence.

State investment has historically dominated in areas which help the growth of private capital, as in the case of the pharmaceutical industry. The public sector produces bulk drugs (accumulating large losses) which are supplied to private formulation units at subsidised prices. Similarly, in the health-care services sector, the government let the private practice of medicine flourish, by subsidising the training of medical personnel from tax-payers funds. Of the qualified allopaths, an estimated 69% are in private practice.

Growth of Health Infrastructure

As shown in ***Table 1***, there appears to be an increase in the number of hospitals, dispensaries and health personnel. However, the growth of the state health sector has not kept pace with the needs of its population. On the other hand, the private health sector has rapidly grown in order to meet the vast demand.

It took the Government, five years after independence, to formally set up the first Primary Health Centre in India.

Not only is the growth inadequate,

Table 2

Intra Sectoral Allocation of Health Plan Funds *(in percentage)*

Subsector	1951-56	56-61	61-66	66-69	74	74-79	80-85	86-91	92-97
Health	64.5	64.9	60.2	41.6	37.5	34.1	27.0	25.8	24.6
Family Planning	0.5	1.3	10.8	36.7	27.3	22.1	15.0	24.7	21.1
Water supply & sanitation	35.0	35.8	28.9	21.7	35.2	43.8	58.0	50.5	54.2

Source: Compiled from various Government and International documents.

but the rural-urban differential is increasing. For instance, in 1956, the proportion of hospitals in rural areas was 39% (and 24% of beds) but by 1986, only 21% of the hospitals (and 18% of the beds) were located in rural areas. While one urban hospital (1986) served 29,115 persons, one rural hopital had to cater to 351,500 persons. Moreover, when we consider access factors (like morbidity rates, sanitary conditions and malnutrition), the rural health sector investment appears to be only a marginalised investment.

Plan Outlays on Health

The ***Table 2*** gives an idea of the expenditure on health, family welfare and water supply. What is obvious is the drop from 64.5% for health in 1951-56 to 24.6% in 1991-92. However, expenditure on population control (euphemistically called family welfare) continued to grow steadily. The minimal and that too declining investment in the health sector exhibits the lack of political will to prioritise this sector in the planning process.

The ***Table 3*** provides a comparative look at government health expenditure in different countries, showing India's low public expenditure on health. When viewed in comparison with the defence budget, the priorities of the policy makers is all too clear.

Impact of Expenditure Compression

Given the importance of Central Government's transfers to States' budgets, expenditure compression at the

Table 3

Central Government Expenditure

[Percentage of total expenditure]

Country	Defense 1991	Education 1991	Health 1991
India	17.0	2.5	1.6
Bangladesh	10.1	11.2	4.8
Srilanka	9.4	8.3	4.8
Pakistan	27.9	1.6	1.0
Costa Rica	-	19.1	32.0
U.K.	11.1	3.2	13.3
U.S.A	21.6	1.7	13.8
Germany	8.3	0.6	18.1

Source: World Development Report, 1993

Centre, particularly in the form of a cut in transfers to states, will have an adverse impact on states ability to fund health and other social sectors. Poorer states like Uttar Pradesh will be more affected by general cuts in transfer.

Share of Central grants in state's expenditure has fallen sharply due to the structural adjustment programme. For instance, in1984-85, Central Grants to Medical and Public Health expenditure was 6.7% which was reduced to 3.9% in 1989-90. Similarly, share for disease control programme has fallen from 41% in 1984-85 to 18.5% in 1992-93. On the other hand, family welfare did not suffer as much (99% in 1984-85 to 74.5% in 1989-90. But once again rose to 88.5% in 1992-93).

The Present Scenario

Policy makers in India have consistently claimed that human development is the ultimate goal of our development programmes. Even if the ideal definition of health as 'overall well-being' is kept aside, and the more prosaic understanding of health as 'absence of disease' is taken, India fares badly according to almost all the indices.

Despite claims in the Economic Survey 1993-94, of a 'considerable expansion' of infrastructure for health services, global comparisons show that this 'expansion' is far from adequate.

Although these indices are not sensitive in presenting the ground reality of morbidity and actual health status, nevertheless, Infant Mortality Rate (IMR) and Maternal mortality provide at least a general indicator of the direction in which trends are moving. The IMR is still high (90/1000) as compared even to other third world countries like China—38/1000. The established market economies have an IMR as low as 7/1000.

Although life expectancy at birth has gone up to 60.3 years, it is still low compared to the world average of 67.3 yrs and 77.9 yrs in the industrial world.

The state of women's health is abysmally low, as evidenced by the high maternal mortality rate of 550/100,000 live births. Communicable diseases have in no way been controlled. Tuberculosis remains the major killer disease of the Indian people, with an estimated 50% population infected with the bacillus. Incidence of cholera is on the rise, the prevalence of leprosy and malaria have not been tackled as yet. In fact, malaria has shown tremendous resistance to the contemporary methods of control.

When almost 50% of the Indian population is living below the poverty line, the causes of ill-health are all too apparent.

When almost 50% of the Indian population is living below the poverty line (HDR, UNDP, 1993), the causes of ill-health are all too apparent. Without adequate nutrition, safe water

and sanitation, capacity to resist disease dwindles further. With an already abysmal state of health, severe pressure from international agencies, like the World Bank is bound to worsen the situation.

Family 'Welfare' or Population Control ?

The Family Planning Programme (FPP) launched by the government of India in the early 50s began to be called 'Family Welfare Programme' supposedly in order to encompass a more holistic approach to family well-being, especially the health of women and children. However, it was more an attempt to disguise its real intentions from the people who had begun to be wary of the coercive target-oriented FPP. The FPP has been allotted a steadily increasing proportion of total Health Plan Funds from .5% in 51-56 to 21.1% in 92-97 while allocation for health has been declining (See ***Table 2***).

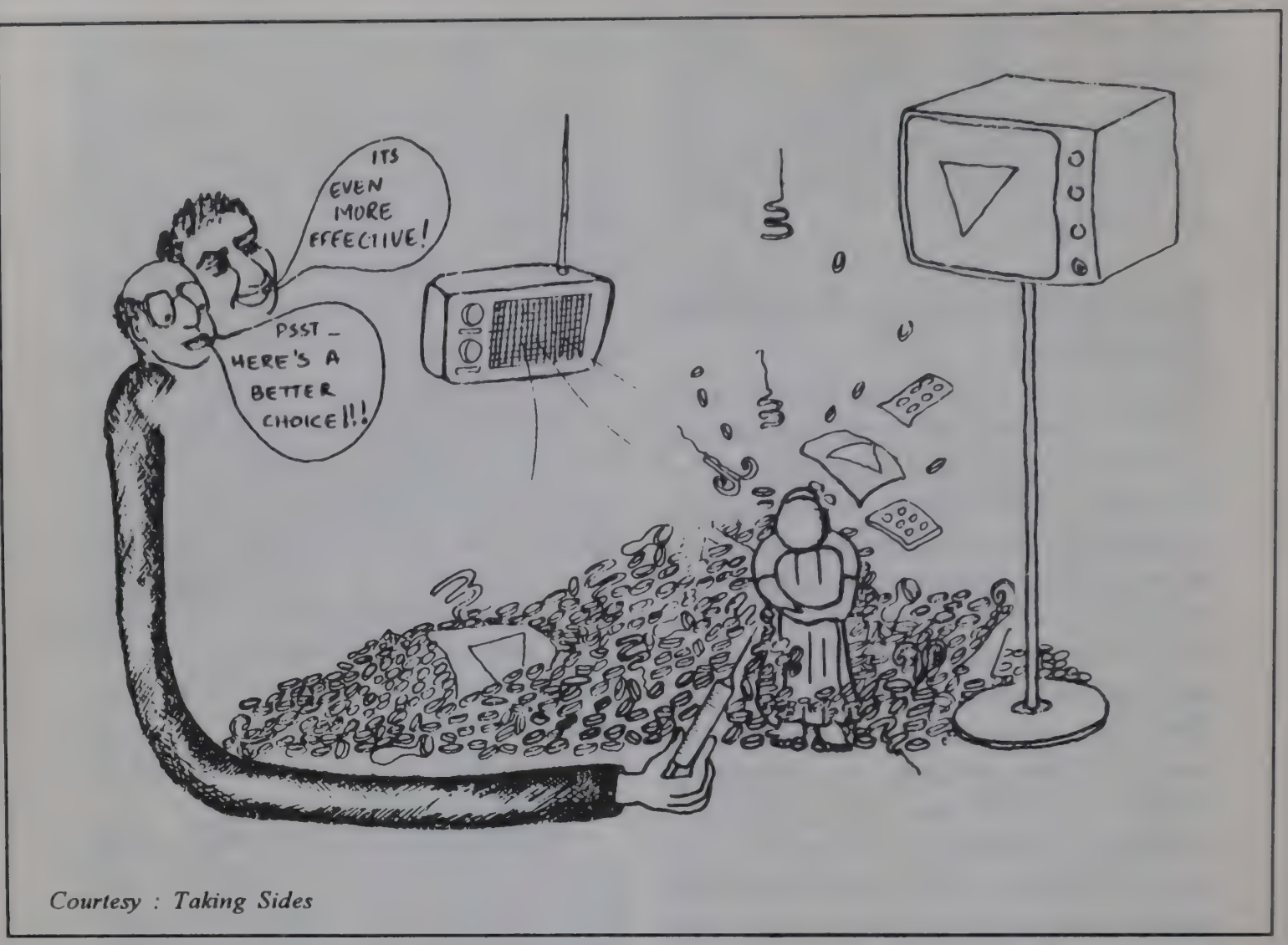
Women have been the worst sufferers, since the merging of Family welfare and Family Planning has meant that women are viewed primarily as baby-producing machines which require control and a consequent neglect of even their basic health problems. Thus, even the much touted Maternal and Child Health Programme (MCH) is almost taken over by the population control lobby. Dangerous hormonal contraceptives are imposed on women in the name of child spacing and enhancing the health of the mother and child. On the contrary, such hazardous methods like hormonal implants (NORPLANT) and injectables, adversely affect the health of the woman and her child.

Women are unable to obtain even basic health services unless they agree to get sterilized, an Intra Uterine Device inserted, or an implant or injection administered for contraception. Health workers and other functionaries at the village level are constantly under pressure to meet targets, and when monetary incentives do not succeed, have to resort to disincentives such as loss of job or daily wages.

This pressure to achieve the overall government target of NRR 1 (i.e. every female to be replaced by only one female), is intensifying with the conditionalities imposed by the WB-IMF tying up loan disbursement with population reduction.

The pressure to achieve the targets is intensifying with the conditionalities imposed by the WB-IMF loans with population reduction.

The liberalised economy impinges directly on women's health and control over their own bodies. It is in this context that a red carpet is laid out for drug multi-nationals. For Instance, Upjohn Co., USA, manufacturers of Depo Provera, an injectable contraceptive, are now



Courtesy : Taking Sides

allowed to market this hazardous drug through Max Pharma, India. Depo Provera has been at the centre of a controversy for almost 20 years, with women's groups raising pertinent questions about the safety of the drug, and its applicability in India where it could be misused to meet population control targets. Similarly, Net-en (manufactured by Schering AG of Germany), has been cleared for marketing in India despite a case filed by women's groups pending in the Supreme Court. It would appear that in the temple of profit, women's health is the last priority. ■

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The World Bank and the Health Sector

"Adjustment with a human face" is the name given to a range of policies designed to cushion the poor, who bear the worst effects of adjustment. According to the Managing Director of the IMF "...adjustment that pays attention to the health, nutrition and educational requirements of the most vulnerable groups is going to protect the human condition better than adjustment which ignores them. This means that the authorities will have to be concerned, not only with if they close the fiscal deficit but also with how they do so."

The World Bank (WB) has made clear its health policy right since 1992 with its document entitled *"India: Health Sector Financing—Coping with Adjustment-Opportunities for Reform."* This first health sector finance study was carried out to enable the Bank to take stock of the pattern and scale of its assistance to this sector. It was also meant to facilitate the G.O.I.'s considerations of the **nature and scale** of external assistance that it might consider appropriate to the health sector. The emphasis is to ensure sustainability—administrative and fiscal—to enable an efficient and effective system to emerge from the process of adjustment. The World Development Report 1993—"Investing in Health" only reinforces its basic policy prescriptions for health care in "low income economies". The W.B. motivation is clearly spelt out in its own words "Because good health increases the **economic productivity** of individuals and the economic growth rate of countries, investing in health is one means of accelerating development". The view of health is that of an economic commodity, the buzz word being **"cost-effective"**, notwithstanding their feeble attempts to assert that health is a "goal in itself". Health, far from being accepted as a basic right of the people, is now being shaped into a saleable commodity, thus excluding those with less buying power from the market. The effort to push for cost-effectiveness analysis of all health interventions reduces health planning into an exercise of costing and attributing values in terms of 'lives saved' 'births averted' and 'money saved'. These measures may sound impressive but are often meaningless, since neither the assumption on which they are based are correct, nor are the data used adequate. Unless the complex nature of health is recognised and the criticality of inter-sectoral linkages understood, the narrow focus on "efficiency" will continue to further push into the distant future, the elusive goal of "Health for All" by 2000 AD.

Health, far from being accepted as a basic right of the people, is now being shaped into a saleable commodity, thus excluding those with less buying power from the market.

World Bank's Prescriptions vs. Reality

PRESCRIPTIONS	REALITY
■ Immunisations	■ Cold Chain for preservation of vaccines is inadequate in rural areas which lack basic infrastructure. Further, substandard vaccines can even increase the incidence of disease.
■ Provide school based health services	■ How many children in India go to school?
■ Information and selected services for Family Planning and Nutrition	■ Family Planning will be the only boom. Information on nutrition does not help in absence of food.
■ Promote programme to reduce tobacco & alcohol consumption.	■ Not the major cause of illness in India.
■ Regulatory action, information and limited public investments to improve household environment.	■ Household environment cannot be 'improved' by information, or regulatory action or 'limited' public investments.
■ AIDS prevention.	■ AIDS prevention is restricted to propaganda and focus on hi-risk groups only. There is no commitment to strengthen basic health services—a big step towards preventing the speed of AIDS.
■ Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences.	■ The World Bank hands out prescriptions to Third World governments on how to maintain the political and social status quo, contain dissent, and prevent sharp polarisation which "may lead to political destabilisation", which can be translated to mean 'movements and struggles for basic rights'.

The existent distortion in health services in India will only get more accentuated with the government following the agenda for health care set by the Bank. The recent budget 1994-95 (of which health care forms only .58%) is an indication of the government's faithful pursuance of W.B. policy, emphasising that the state is no longer interested in ensuring an efficient, accessible health care system. The health care agenda is increasingly being set not, certainly, by the people but not even by the Indian State.

The National leprosy control programme (22.5%) and the National malaria eradication programme (22%) make up almost half the Health budget for 1994-95. While last year, the tuberculosis control programme had received a 159% increase over the previous year, this year it is the malaria eradication programme, with a 169% increase. The National AIDS Control Organisation which has been accorded a 14% increase comprises 19.8% of the public health budget.

Bank's stamp on Indian Budget 1994-95

[Rs in crore]

Budget Head	93-94	94-95	% increase
Health expenditure	844	915	8.4
Family Planning	1,285	1442	12.3

These variations do not occur because they are backed by epidemiological evidence or are a result of programme evaluations but in deference to WB stress on control of communicable diseases. The World Bank has expressed its concern over malaria eradication and blindness control programme, which the WDR, 1993 suggested be strengthened. This is in addition to a massive WB loan of Rs 554 crore for blindness control programme in seven states. Similarly, the enhanced budget for Family Planning is in accordance with the World Bank belief that population reduction is a necessary condition for structural adjustment programmes to succeed.

The Annual Plan '94 states that the government priority is no longer in enlarging the health infrastructure but selectively strengthening facilities. Instead, several proposals in the 1994-95 budget further strengthen the private sector, especially the corporate hospitals. In the current budget, any institution can now import medical equipment at a concessional customs duty of 15% and the earlier certification has been scrapped ostensibly because of bureaucratic delays. (Certification was supposed to ensure that a proportion of the services had to be for non-paying patients).

As part of the proposal to liberalise taxation of prerequisites, medical bills paid by employees to recognised private hospitals will now be considered deductions for income-tax assessments.

In the context of promotion of

Courtesy : Taking Sides

private and corporate sector hospitals and their staff requirements, the government is positively encouraging private professional colleges by offering income-tax concessions on repayments of loans taken to finance education in such institutions.

Medical education and training and research has received a steadily decreasing allocation since 1992, displaying a lack of prioritising indigenous generation of knowledge.

The present budget of 1994-95 is ample proof that the state is increasingly shrugging off its welfare responsibilities and openly encouraging private enterprise in the provision of health care. Despite limited purchasing power, inadequacies in the government health institutions have led to rapid increase in the market for medical care as a commodity. People are forced to pay because it is often a question of life and death. A host of medical peddlers have cropped up to exploit this increasing market based on human suffering, disability and death.

Real Causes of Ill Health

The Bank's contention that 'targeting' will improve the health status of the poor is absolutely unfounded. In the absence of an approach which is based on equity, a mechanistic and artificial focus on the "poor" will not achieve genuine equity. Targeting the poor sees them in isolation and is based on the acceptance of existing social structures and institutionalised injustice. **It merely attempts to help the poor adjust better to the situation, rather than change their situation.**

The history of medicine reveals that the current major causes of disease or death in the third world, are communicable diseases, nutritional disorders, maternal and perinatal diseases. These were conquered in the West long before antibiotics and vaccines became available. The major reduction in infant mortality and increase in life expectancy resulted from an increase in food availability due to better wages of the working class and their improved bargaining power. Diseases of poverty cannot be cured with medicines and 'targeting'; they need elimination of poverty through a more equitable distribution of resources.

Diseases of poverty cannot be cured with 'targeting' and medicines, they need elimination of poverty through a more equitable distribution of resources.

Unhealthy Dictates of the Bank

- **Foster an environment that enables households to improve health :**
- Expand investment in schooling, particularly for girls.
- Promote the rights and status of women through political and economic empowerment and legal protection against abuse.
- **Improve government spending on health :**
- Reduce government expenditures on tertiary facilities, specialist training and interventions.
- Finance a package of public health interventions to deal with infectious diseases, prevention of AIDS, environmental pollution and behaviours that put other at risk (eg. drunk driving).
- Improve management of government health services through decentralisation of administrative and budgetary authority and contracting out of services.
- **Promote diversity and competition**
- Government can promote diversity and competition in provision of health services and insurance by adopting policies that:
- Encourage social or private insurance.
- Encourage supplies both public and private. Domestic supplies should not be protected from international competition.

The Bank labours long and hard to evade this basic reality. All its attempts to show that the poor suffer from ill-health due to factors like misuse of funds, apathetic doctors, inefficient management, amount to concentrating on peripheral issues and refusing to look at the basic underlying cause i.e. an economic system in which 423.0 million i.e. 49% (UNDP, 1991) population is in "absolute poverty". These problems can be solved only by radically restructuring socio-political relations.

In Kerala, despite a per capita income below the all-India average, health indices are well above the all-India average. The major drop in infant mortality in Kerala took place between 1951-1960, the period during which major land reforms, enforcement of minimum wages and child labour laws saw a marked improvement in the condition of the working class.

World Bank's Diagnosis

According to the World Bank, the objectives of a health system are to improve outcomes, control costs, satisfy users and increase equity. But genuine equity can never be achieved since delivery depends on capacity to pay, so the poor can never hope to 'buy' health. Policy instruments, however, do not correspond to individual objectives. What governments actually do is build facilities, buy equipment and supplies, hire and train people, set fees or other service conditions, regulate providers and insurers, disseminate information, determine overall policy and maintain surveillance of disease conditions or other variables. Misallocation and inequity, according to the WB, are caused by mistakes in

Health care in US

Privatised, Inefficient, Costly

The US spends more on health than any major industrial nation and is probably the only country in the west without universal health coverage. In 1992, the country spent $838 billion (14%) of its GDP on health care. While such outlays produce impressive specialists and hi-tech medical equipment, 37 million Americans (out of a population of 255m) are without health insurance, with 100,000 people losing coverage every month.

The main cause of the higher cost of US health cover is its profit driven system of insurance. The emphasis is on maximizing costs so that no one gets blamed for inadequate attention. The American system, a combination of public and private health care, with private insurers acting as the main administrators, results in the poor and at risk populations (elderly, women, migrants) getting inferior or no services at all. The US has a higher Infant Mortality Rate, and lower life expectancy than other industrial nations.

Is this the model of development our planners wish to emulate ?

deciding what facilities to build, where to locate them, how to staff them, and what services to provide.

According to the Bank, much of governments' failure to achieve better health outcomes derives not from the wrong choice of objectives but from the wrong choice of instruments—in particular, from too much reliance on direct provision of care and central control of health facilities and too little use of the financial, informational and regulatory instruments at the disposal of the government. Again, this management approach takes health out of the realm of a basic right, into a commodity to be sold.

Now that the Indian government is obeying the prescriptions of Dr. World Bank, one can expect less "direct provision of care", while the government takes a back seat into 'informational' and 'regulatory' mechanisms. The World Bank justifies cut backs in public health expenditure by emphasising that "how money is spent by the Indian government appears as important as how much money is spent". The Bank goes on to cite the example of China which has less public spending on health, but has significantly better health outcomes than India. What is conveniently forgotten is that China puts far more emphasis on equitable resource distribution.

Cut-backs in Public Health

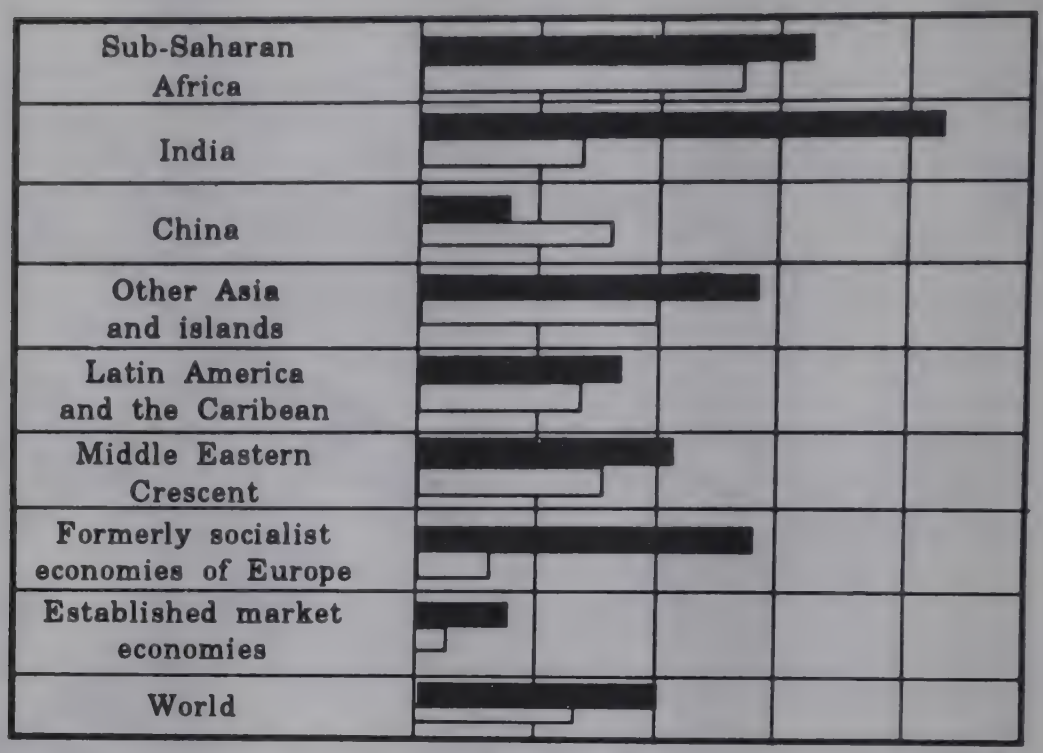
"If households pay the total cost of water and sanitation services because of the productivity (save on fuel to boil polluted water, saving on time and energy of women who have to collect water from distant sources) and amenity benefits, substantial health gains are an added bonus achieved at no cost

Courtesy : Taking Sides

per DALY gained. When willingness to pay is much less than costs, it is usually a mistake to justify subsidies on the basis of health benefits alone." The fact that the Bank seems to ignore **capacity** to pay, and hinges it on '**willingness**' alone—is a completely market approach. The Bank goes on to state that subsidies "... compromise the demand-driven approach to service provision (i.e. provision of services that people want and are willing to pay for); lack of accountability and inefficiency are the inevitable consequences." It further adds another note of discouragement "... if publicly financed investments in these services are being considered for health reasons, it should be noted that such investments generally cost more per DALY (Disability Adjusted Life Years : a measure that combines healthy life years lost because of premature mortality, with those lost as a result of disability) gained than other health interventions recommended in this report".

According to above figure, about

Population without Sanitation or Water Supply services by demographic region, 1990



Note: Coverage is defined in accordance with local standards.

Source: World Health Organisation data.

85% of India's population does not have sanitation, and 25% does not have access to water supply. Yet this does not justify state intervention according to the Bank, which recommends "encouragement of private sector and NGO involvement in provision of amenities like water and sanitation."

The Bank ignores the reality of present private sector involvement which is limited to providing bottled mineral water to foreign tourists and the Indian elite.

Withdrawal of State

Not only water and sanitation, in keeping with the trend of reduced state involvement, the Bank recommends a virtual handing over of the health sector especially family planning, to non-governmental organisations (NGOs).

The W.D.R. '93 states that NGO's, particularly those related to religious institutions make important contributions to the provision of health services in many low-income countries. In Tanzania and Haiti, almost 50% provision is by NGOs, while NGO's account for more than 10% clinical services in India and Indonesia.

What is surprising is the manner in which the Indian Government is accepting the recommendations of the Bank without initiating a public debate and discussion on these issues. ■

Sapping Health

As mentioned earlier, the burden of macro structural adjustment falls on the Health sector, an internal process of adjustment in Health sector is initiated in order to match with the macro structural adjustment process. This internal process has various components. Among the most well-known are privatisation of health services, charging of user fees in state-run health services, withdrawal of state from health services, lay off of doctors, nurses and medical personnel, cuts in government spending on health and greater access to foreign captial in the Health business. These components of adjustment in health sectors have been implemented in various degrees in many third world countries.

Perhaps, Jamaica provides the best case study of the effects of SAPs in the Carribbean because it has had the longest experience of these policies since 1977 by the IMF and the Bank.

In Jamaica, health services have declined due to lack of budgetary support. In 1979, the health expenditure in Jamaica was 3.3 % of GDP which was reduced to 2.7% in 1987.

This has resulted in:

- old and poorly maintained infra-structure
- inadequate medical supplies
- severe staff shortages in many areas.

Health indicators for Jamaica have been higher than average for middle income countries. Life expectancy was 70 yrs. and Infant Mortality Rate (IMR) 26/1000 in 1978.

In 1990, however, the Director General of the Pan American Health Organisation (PAHO) warned that there were definite signs of deterioration. PAHO's present estimate of infant mortality is 27-30 per 1000. Both typhoid and gastro-enteritis, a disease associated with malnutrition, have shown an upturn in the 80s, continuing into the 90s.

Unfortunately, the same process of adjustment in health sector is being carried out in India without learning lessons from Jamaica and other third world countries.

User fees

User charges for Public Health Services in developing countries have sparked much debate since the World Bank endorsed the concept in 1987 in a policy study on health financing. Studies on the effect of user fees are inconclusive and contradictory. One reason is that some researchers have failed to calculate the true cost to patients

In many developing countries where user fees have been introduced, recovery has been low because this was accompanied by reduced public expenditure on health.

of treatment at government clinics. People often pay dearly for supposedly "free" services.

The WDR 1993 highlights the findings of recent household surveys in India, Indonesia and Vietnam, which indicate that "each visit to a government health centre actually costs patients two to three times the amount of the low official fees. Bribes aside, the indirect costs such as transport and the opportunity cost of time spent seeking care are substantial."

Instead of steps to revamp inefficient and inadequately staffed and stocked public health services, the W.B. justifies introduction of user fees, which would definitely restrict access to care especially for the poor.

"Since patients", according to the WDR "are already paying for supposedly free or low-cost health care, new user fees, when accompanied by a reduction in indirect costs and improvement of services, may increase utilisation." The poor benefit the most from these changes, according to the W.B., since facilities used fees to fund services not previously available locally, so poor patients avoided costly travel, and the actual cost of care declined. This seems to be more a case of wishful thinking, since user fees will double the burden of "purchasing" basic health services, which is the need of the hour, rather than sophisticated high-tech medicine.

On the issue of 'better targeting' of public services and recovery of costs through 'user charges' there is now considerable literature which would question some of the hypotheses of the

Who is Paying for Whom ?

"Often a point is made that government hospital services are free, with an implication that they are doing charity. Let us go a step back and see, where does the money for the government comes from? From the people, in fact. Where does the Government come from? From the people."

"The people place their money in the hands of its agent—the Government to spend it judiciously and justice would have it that the most essential services like education and health be covered."

"In charging the people for those services, the government is making the people pay for what is theirs, already, for they have caused these services to come into being. It does them further disservice, as this double taxation can be afforded only by the rich, so the people who made only the first payment actually will get nothing while those who can make the second payment will get all the benefits."

"Thus the Government is stealing from the poor majority and enriches the rich, whom it actually comes to represent."

"We condemn the Government of the Rich. We demand—Remove All Charges in Government Hospitals."

--Delhi Medico Scientists Forum

Putting Back the Clock

Pre-Independence India did not have the capacity to manufacture drugs from the basic stage, and people were at the mercy of foreign drug companies. Lakhs died in typhoid epidemics as they could not afford drugs.

Boehringer Mannheim India Ltd. (BMI) Indian collaboration of Boehringer Mannheim, Germany, in its plant installed at Thane 35 years ago, manufactured chloramphenicol, a drug used in the treatment of typhoid. The capacity of BMI was 75 metric tonnes a year—a major portion of India's requirement of 200 metric tonnes per year.

Rather than import L-base for the manufacture of chloramphenicol, BMI chose to manufacture it from the basic stage by converting benzaldehyde.

In 1991, the cost of manufacturing 1kg of chloramphenicol from indigenous material was Rs 1,171. The international market price of L-Base was $75 per kg, with a customs duty of 110%. The cost of manufacturing 1kg of chloramphenicol from imported material was thus Rs 2,875.

By 1992, the NEP had its effect on the pharmaceutical industry. The supply of L-Base in the international market had far outstripped the demand, and prices plummetted from $75 to $ 29.50 per kg. The Indian government obligingly slashed customs duty from 110% to 25%.

In March 1993 the customs duty was removed altogether, along with countervailing duty. Foreign manufacturers of L-base found a huge new market in India.

By 1994, BMI had closed down the unit for converting benzaldehyde, throwing 200 workers out of their jobs. The Union resisted the move, and put forth its contention that the foreign manufacturers had slashed prices only in order to penetrate the vast Indian market. Once indigneous manufacturing capacity was destroyed completely, they would steeply hike prices.

Moreover, the government is utilizing foreign exchange to buy a drug which had been manufactured indigenously for over 35 years.

These developments have reversed the situation to the pre independence era, when typhoid epidemics took thousand of lives, with people unable purchase costly drugs.

WDR.

In many developing countries where user charges have been introduced, recovery has been low because this was accompanied by reduced public expenditure on health so that the quality of services suffered. Users would be willing to pay fees only if quality of services improves simultaneously, which requires more public spending.

Studies in some African countries *(Creese, AL 'User charges for Health Care: A review of recent experience Geneva WHO, 1990)* showed that after the introduction of user fees in public hospitals, the poor got even further marginalised. The issue of equity is immediately raised in this context.

Further, in most developing countries the introduction of 'user fees' is accompanied with a cutback in investments, therefore, the revenue generated by the former is just about enough to compensate for a cut in investment. Thus the question arises of how cost-effective is user-fees in reality?

The move to introduce user fees in the capitals' hospitals is meeting with at least some resistance (See Box). With almost 50% of India living below the poverty line, introduction of user fees would have serious implications for their health.

The move to introduce user fees in the New Delhi's hospitals is meeting with at least some resistance.

Privatisation

"Investigation done at Government Hospitals will be charged. Except for the most routine investigations, laboratory and radiological investigations done at Government Hospitals will be charged. The rates are about half of those charged by private labs", says a newspaper report.

This process started with the Rupee one OPD ticket at All India Iinstitute of Medical Sciences at New Delhi [AIIMS]. Next, costly investigations like CT scans were charged to partially offset their cost. Next it was the turn of histopathological and cytopathological specimens at AIIMS. The rationale was that the pathology department was running short of Rs 1-2 lakhs/yr in maintenance cost. The money generated was to cover up budgetary deficits.

Following this, at Post Graduate Institute of Chandigarh, the OPD ticket was priced at Rs 5/-. The concept of consultation fee makes an entry. Then at PGI routine investigations are charged. The rationale was to generate the entire maintenance costs.

Activist groups have pointed out that the maintenance cost of central lawns is Rs 2 lakhs per year and the over all maintenance cost of a hospital like AIIMS is in crores.

These anti-people

Private Health Sector : A Fact Sheet

- Share of private health sector : 4-5% of GDP nearly Rs 20,000 crore per year.
- Private household expenditure is nearly 4 to 5 times more than state exependiture on health.
- One of the largest private health sectors in the world, providing 70% of care in India.
- In 1963-64, a study showed that 61% allopathic doctors were in private practice. A study in 1993 showed that 92% doctors were in the private sector.
- There are reasons to believe that the number of hospitals in the private sector is much larger than what available data suggests.
- A recent development in private health sector has been the growth of corporate hospitals and medical industrial complex. The Apollo Hospitals Enterprise, set up in 1983, within five years had recorded a turnover of Rs 11.48 crore and a net profit of Rs 1.66 crore.
- In a span of 2 years (1984-86) over 60 diagnostic centres in Bombay city alone, have entered the market, with an investment of over Rs 200 crore in sophisticated equipment.
- "Cut practice" ratio in Bombay for referring patients to laboratories and diagnostic centres is as high as 30-40%.
- 70% hospitals where routine caesareans were performed are privately owned. While normal deliveries are charged around Rs 300-700, caesareans are charged Rs 2000-Rs 5,000.
- While the state health sector services have much to be desired, the profit motive does not appear to override all other concerns.
- The main source of continuing education for doctors are the medical representations of the pharmaceutical industry.
- A study in 1991 revealed that a General Practioner's net income on an average works out to about Rs 17,000 per month and "specialists" earn on an average Rs 40,000 p.m. while nurses are paid around Rs 600 per month.

Hazards of Private Practice

Prescriptions	In Govt. Clinics	In Private Clinics
	(in percentage)	
Irrational drug combinations	2.0	28.9
Hazardous drugs	0.5	9.6
Unnecessary drugs	28.4	45.7
Unnecessary injections	24.2	26.5

measures were tested at the premier institutions, under the facade of their being referral institutions and not really oriented exclusively towards service. Now, the same has been extended to all central institutions and very soon will involve all government hospitals in Delhi.

There are plans afoot to charge for speciality clinics at commercial rates, at premier institutes. So the concept of making profit out of public hospitals is being actively considered.

In this context, it would be wise to consider the other type of privatisation permitted in government Health Services—private practice allowed in Bihar and U.P. for example.

The process of privatisation in education and in medical services has resulted in a confluence privatization of medical education.

Besides internal adjustment in the health sector, structural adjustment in other sectors of the economy, especially industry, agriculture and trade has both direct and indirect linkages which can adversely affect the health sector thereby affecting the health conditions of millions of people in India. In the following sections we will try to see the impacts of adjustment in industry, trade and agriculture sectors on the health sector.

Structural adjustment in other sectors of the economy, especially industry, agriculture and trade has both direct and indirect linkages which can adversely affect the health sector.

ADJUSTMENT, PHARMACEUTICALS AND HEALTH

Indian Drug prices were amongst the highest in the world at a time when India was following the colonial Patents Act, the Patents and Designs Act of 1911, which was a product patent regime. The adoption of the process patent regime following the Patents Act of 1970 has radically changed the price situation in the Indian drugs industry in the decades of the 70s and 80s. Drug prices are now amongst the lowest in the world. (Sri Lanka and Indonesia, being members of Paris Convention, have a product patent regime and Patent Act of 1911 resulting in higher drug prices in these countries).

Increase in price of drugs and pharmaceuticals is already obvious, now that the process patent regime is changed during Uruguay Round of GATT negotiations (Dunkel proposals). Along with this, TRIMS (Trade Related Aspects of Investment Measures) also have been accepted... Drug Price Control Order (DPCO) can no longer function as a price control mechanism. The new Drug Policy, which has just been declared is one which toes the line of international interests.

Heralding the New Era

Portents of things to come could be seen as far back as 1986, at the 35th World Health Assembly. The Health Action International (HAI) team - a network of activists and organisations, lobbied for a strong Resolution on Rational Drug use. The US delegation, guided by Heritage Foundation (the right wing think tank) threatened to withdraw its 25% budget support to WHO.

What ensued was a resolution with no teeth and the assertion that WHO was not a supernational body, and that national governments had to make their own policies on regulatory mechanism to protect their people. WHO, one is told, cannot be expected to do this.

From Bad to Worse

Patenting of medicinal plants will adversely affect indigenous systems of medicine, such as Ayurveda. Would obtaining a patent by some pharmaceutical TNC on a certain plant extract make its use by others illegal ? This is an important issue at a time when modern allopathic medicine is being questioned, and its applicability in the Indian context doubted. Moreover, drug companies are attempting to commercialise even traditional systems of medicine, which had earlier escaped the clutches of "big business"

ADJUSTMENT, INDUSTRY AND HEALTH

The control of Indian capital and industry by international interests has a direct bearing on the quality of people's lives. The search for higher profits has led not only to the neglect of worker's welfare, but in fact has created a situation wherein work hazards have increased and become more lethal. The fact that the technology transferred is mostly outdated and lacking in adequate safety mechanisms, becomes crucial to the health of workers in view of the highly toxic materials that such units handle.

The fallout of transfer of hazardous industrial units are manifold : adverse health status of workers; pollution of immediate surroundings and consequent impact on health; long-range effect of pollution of rivers, ground water, and air. For instance, Lote Parshuram, a remote rural area in the Konkan region of Maharashtra state, which has been recently flooded with a number of hazardous chemical units, even witnessed showers of acid rain.

The search for higher profits has led not only to the neglect of worker's welfare, but in fact has created a situation wherein work hazards have increased and become more lethal.

India has already approved the investment of several multinationals with a notorious safety record, such as Imperial Chemical Industries (UK), Du Pont, Monsanto, Cargill (USA), Shell (Netherlands) and

Ciba Geigy (Switzerland). Ciba Geigy, infamous for having tested pesticides on Egyptian children, plans to manufacture Monocrotophos, (classified by the WHO as a "highly hazardous" pesticide) in collaboration with its Indian counter part Hindustan Ciba Geigy. This product is banned or severely restricted in many countries. However, in the race to capitalise on the vast market potential in India, pesticide companies are vying with each other to gain a foot hold. And all this at a time when the world, having realized the hazards of chemical pesticide use, is moving towards biological pest control and organic farming.

It is interesting to mention here the ideology and philosphy of the Bank as articulated by Mr. Lawrence H. Summers, Vice President, Research and Policy division in a Memo in 1991. He says, "just between you and me, should not the Bank be encouraging more migration of the dirty industries to the LDC's? I can think of 3 reasons" :

1. "The measurement of the costs of health impairing pollution depends on the foregone earnings from increased morbidity and mortality. From this point of view, a given amount of health impairing pollution which will be done in countries with the lowest wages. I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable and we should face up to that".

2. "The costs of pollution are likely to be non-linear as the initial increments of pollution probably have very low cost. I've always thought that underpopulated countries in Africa are vastly *under polluted,* their air quality is probably vastly inefficiently low compared to Los Angeles or Mexico city. Only the lamentable facts that so much pollution is generated by non-tradeable industries (transport, electrical generation) and that the unit transport costs of solid waste are so high, prevent world welfare enhancing trade in air pollution and waste".

3. "The demand for a clean environment for aesthetic and health reasons is likely to have very high income elasticity. The concern over an agent that causes a one in a million change in the odds of prostrate cancer is obviously going to be much higher in a country where people survive to get prostrate cancer, than in a country where under 5 mortality is 200 per 1000. Also, much of the concern over industrial atmospheric discharge is about visibility impairing particulates. These discharges may have very little direct health impact. Clearly, trade in goods that embody aesthetic pollution concerns could be welfare enhancing. While production is mobile the consumption of pretty air is non-tradeable".

"I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable and we should face up to that."

Vice President, World Bank

The arguments against all of these proposals for more pollution in LDC's

The Politics of Hazardous Wastes

The first reported incident of attempts to export hazardous wastes from the US followed quickly upon enactment of the Resource Conservation and Recovery Act. In 1979, the State Department learned that Nedlog Technology of Colorodo, had offered President Stevens of Sierra Leone "upto $25 million" in advance for permission to dispose hazardous wastes from the US in that small African nation. Under pressure from his constituency and citizens of neighbouring Nigeria and Ghana, President Stevens rejected the plan in 1980.

(intrinsic rights to certain goods, moral reasons, social concern, lack of adequate markets, etc) could be turned around and used more or less effectively against every Bank proposal for liberalisation.

In reply to Mr. Summers memo, Mr. Jose from Brazil commented, "It was almost a pleasant surprise to me to read reports in our papers and then receive copy of your memorandum supporting the export of pollution to Third World Countries and the arguments you present for justifying it. Your reasoning is perfectly logical but totally insane. It underlines what I just wrote in a chapter on the absurdity of much of what goes for 'economic thinking' today as part of a book that will be presented at the Rio-92 conference. Your thoughts will be quoted in full in the book, as a example of the unbelievable alienation, reductionist thinking, social ruthlessness and the arrogant ignorance of many conventional 'economists' concerning the nature of the world we live in."

If it came from some insignificant teacher in a third grade school in the backwoods it might laughable, but coming from a Harvard professor and a man in your position it is an insult to thinking people all over the world. If the World Bank keeps you as vice president it will lose all credibility. To me it would confirm what I often said as an environmentalist, years ago, fighting ecologically devasting and socially disrupting World Bank "development projects", namely that the best thing that could happen would be for the Bank to disappear".

Hazardous Wastes in India

The dumping of hazardous toxic wastes produced in northern countries into India, is yet another face of the liberalised economy. Greenpeace recently reported that in August 1993, U.K. exported over 500 tonnes of lead waste to India, following a one million kg export of the same from Canada in 1992. Pepsi Cola Corporation is alleged to have exported 7000 tonnes of plastic wastes from USA to India in 1992. The experience of becoming a dumping ground for the industrialised North, where environmental lobbies are strong enough for the "not-in-my-backyard" argument to work, is all too familiar for a number of other countries which have come under SAP. This open-door policy can go even to such absurd extents as importing cowdung from Holland. The label "Enviro dung" aims to hide the fact that the dung may contain residues of the chemicals,

which contaminate the ground water—the major reason Holland wants to get rid of the dung.

ADJUSTMENT, AGRICULTURE AND HEALTH

The emphasis on generating foreign exchange, and hence on export production, has profoundly, negatively and simultaneously affected the activities of rural women and the environment in which they live and work. The shift of land to the production of export crops for instance, forces women to shorten fallow periods and farm more and more marginal lands. Certain types of agricultural industrialisation further contribute to erosion, desertification, pollution and salination of the land upon which women depend for household needs, this inhibits their production and forces them to spend more time gathering increasingly scarce resources, such as fuel and water. Given the fact that only 10% of the Indian rural population has access to clean water, and that about 80% health problems are water related, the diversion of a scarce resource to water intensive crops (sugarcane, mulberry for silk production) is bound to adversely affect health. Women's health is more vulnerable in the context of gynecological disease and childbirth related complications, which an adequate supply of clean water would go far to alleviate. For adjustment policies to increase food productivity over the long term, policymakers must look at what is happening to women and other marginal farmers and the land they work. Increased use

The Nigerian Experience

Following the adjustment related supply shifts into cash crops, there was a decline in output levels of foodgrains after 1987. This poses a key question about the extent to which SAP induces competition between food and cash crops, encouraging the cultivation of the latter at the expense of the former. The objective of substituting domestic raw materials for imports was explicitly stated in the SAP programme. Cotton, which offers scope for import substitution, is an alternative crop to grains in the northern region. Lint and seed cotton prices increased by about 50% devaluation. The price increase encouraged peasants to expand cotton production. This emerged as a result of a shift from the cultivation of maize and other grains, the prices of which were weakening in 1985-86.

Moreover, profitabililty of farming food crops after SAP was affected by rising input costs. Marketing boards have been ineffectual and inefficient, leaving food products largely to market forces.

In terms of equity, regional biases in cultivation of food and cash crops, and differentiation among the peasants, are likely to skew any benefit of increased prices and production towards particular regions and classes of farmers. Inter-regional and inter-peasant income inequalities may be sharpened.

Hunger in the Hinterland

Starvation in Bijakura in Surguja district of Madhya Pradesh led to the death of 12 persons since Sept.1991. Failure of the monsoon resulted in almost no grain stocks, forcing the tribals to eat baijan—a poisonous root. There is no work available, and the few who are employed by the government departments are not being paid their wages. Most men in the area have migrated to U.P. and Bihar, leaving behind only women, children and the aged.

The Public Distribution System (ration shops) in these villages is non-existent. What little is available (through a mobile system) does not take into account the distressing conditions of the tribals. A mobile fair price shop van was parked at Langri village, near Bijakura, on March 12. The villagers said that it was the first time it was there. But the people did not have the money even to buy from the PDS.

[Indian Express, March 22, 1992]

of chemical pesticides and fertilizers to sustain export oriented agri-business has an adverse impact on the environment and people's health.

Distorted Development and World Hunger

The ideology of development, operationalised at its best by the policies of the WB and other multilateral development banks, has created a threat to survival on an unimaginable scale. In 1983 there were no African countries among the big debtors. Today, the external debt of the 42 famine stricken sub-Saharan economies is in the order of US $ 130-135 billion.

The Ethiopian famine which has killed more than a million and affected almost 8 million is usually blamed on rainfall failure. But its seeds were sown in the 1960s when the rich Awash Valley was dammed and developed, with World Bank finances and FAO plans. Land and water was diverted from subsistence farming and pastoralism to large corporate agriculture controlled by Dutch, Israeli, Italian and British firms. About 150,000 people were displaced downstream, in addition, about 20,000 were uprooted upstream. When drought struck the Wollo region in 1972, 30% of the displaced Afars, a pastoral tribe, died. In 1984, the Afars were starving again and having to fight with settled farmers to derive sustenance from an eroded land base.

In India, the drop in internal consumption of food has been matched by an increase in rice exports. In the words of Tata Exports: *"the devaluation was very good to us, together with the lifting of quantitative restrictions on rice exports, we expect to increase our sales of rice to the world market by 60%"*

The latest in the assault on the poor and particularly women, who are the custodians of the family food basket, is the boost given to the food processing industry which churns out ready to eat foods by taking away the raw material accessible to the poor and returning it with value added and rendering it beyond their purchasing capacity. ■

Food First ?

There is no denying the fact that sufficient quantity and quality of food is essential for good health. Good nutrition is the most fundamental pre-requisite for a person's well-being. The second half of this century displays a lack of improvement in socio-economic conditions and health services in India. This has contributed to the addition to the category of poor, malnourished persons who are weaker and more vulnerable to exploitation and control by the rich.

Long debates have been carried out over whether it is calorie insufficiency or protein insufficiency which is the root cause of malnutrition. In India, attention was initially focussed on protein deficiency alone. Nutrition scientists are particularly vulnerable to manipulation by market forces, which in turn control political forces. For instance, this diagnosis of malnutrition resulted in a huge market for 'tonics' and other fraud supplements.

It has taken many years, as well as pressure from grass-root groups, for those in power to accept that calorie deficiency is of central concern. The issue here is that a vast majority of persons simply does not get enough food. Estimates of the extent of malnutrition are controversial, and revolve around a mechanistic view of measurement in terms of protein/calorie consumption and relating this to the allowance recommended by various national and international bodies. However, we will quote one such estimate to get some idea of the problem. The prevalance of mal-nutrition among children below 5 yrs of age is 63% in India, according to the WDR 1994. Calorie consumption is directly linked with purchasing power and the extent of poverty. Taking cognisance of studies such as that by Dandekar and Rath in the 60s, which showed that about half of India's population does not get an income sufficient to purchase its minimum calorie needs, the government took certain measures. Apart from specific nutritional interventions such as school mid-day meal programmes, Vitamin A supplements, the Integrated Child Development Services, etc. a major strategy has been food subsidies through 'ration shops'.

Cuts in Food Subsidies

Notwithstanding the inefficiency in implementation and outreach, food price subsidies have made significant contributions to improved nutrition in a number of countries. Food Price Subsidies (FPS) may influence the nutritional status in three ways—

- They increase the purchasing power of recepient households because they can purchase a larger amount of food at the same cost.
- Subsidies may reduce the prices of food relative to the prices of other goods, thereby encouraging households to buy more food.
- Subsidies may make certain foods cheaper, relative to other foods, and in this way change the diet composition.

Food for Thought ?

The Bank claims that inducing behavioural change - thus enabling families to improve their diets even without additional income is often the most cost-effective way to improve nutritional status. It goes on to show how "maternal tutoring" programmes in Indonesia and Columbia are supposed to have reduced malnutrition and affected children's height and weight as much as the effects of extra food (sic)!!

"Letting people buy basic food stuff more cheaply can, in theory, increase intake of particular foods, but there are often practical problems in targeting subsidies to needy households. Targeting by locale or by commodities eaten primarily by poor people is more efficient than wasteful general subsidies, but less precise than targeting according to specific needs.

As with direct transfer of income or of food, subsidies are more likely to improve nutrition and health when they are combined with nutrition education and related health interventions.

There is a strong case for government intervention to improve health by improving nutrition but not for interfering generally in food markets, except in extraordinary conditions such as famine, says the Bank report.

However, one can break this myth with very little effort. In fact, even an institution like the UNICEF begs to differ from the World Bank strategy. The UNICEF stresses that care should be taken to introduce nutrition education programmes only in those cases where insufficient knowledge is the most limiting constraint. Households with very severely malnourished members are frequently deprived of other basic necessities as well, and insufficient incomes are the most limiting factor. A case in point is a study in Philippines which showed that nutrition education was effective only in households that also received a food subsidy.

Thus, while forces of SAP imposed by the WB, leading to more severe impoverishment and lack of basics like food, efforts are made by these very agencies to cloud the issue, claiming that education or management principles will uplift the health status of the majority.

Amravati Tribal Children die of Malnutrition

At least 160 adivasi children below the age of 6 years died of malnutrition in a period of two months (July-August 1993).

Government has stopped the supply of nutritious sukhdi (a mixture of wheat flour and jaggery) given as supplementary diet to school-going children. The adivasis have also been deprived of their traditional livelihood because of stricter forest regulations. Deaths in the July-Sept period increased in the rainy season because the water is polluted. Several adivasis starve as they cannot get work.

Stopping food subsidies to marginalised populations can become a matter of life and death. In such a situation, "nutrition information" and "maternal tutoring" has no meaning.

All the above are extremely relevant to TWCs, where people have to spend more than half the household income on food. Pre-schoolers, pregnant and lactating women are the household members most at risk of malnutrition with decreased consumption of food.

FPS have significantly increased real incomes of the poor in a number of countries, and it also positively influenced household food consumption. The poorest Indian consumers of FPS increased their calorie consumption upto 18%, and low-income urban consumers in Bangladesh consumed about 250 calories more per person daily due to the rations.

A study way back in 1979 itself, found that the weight for age of children in Kerala would fall by 8% if the ration scheme was discontinued.

The ***Table*** on this page shows that in a country like India, where families already spend more than half their household income on food (as compared to 10% in USA). Cutting food subsidies would increase the already heavy burden on poor families, who would then have to spend even more to remain above the starvation line.

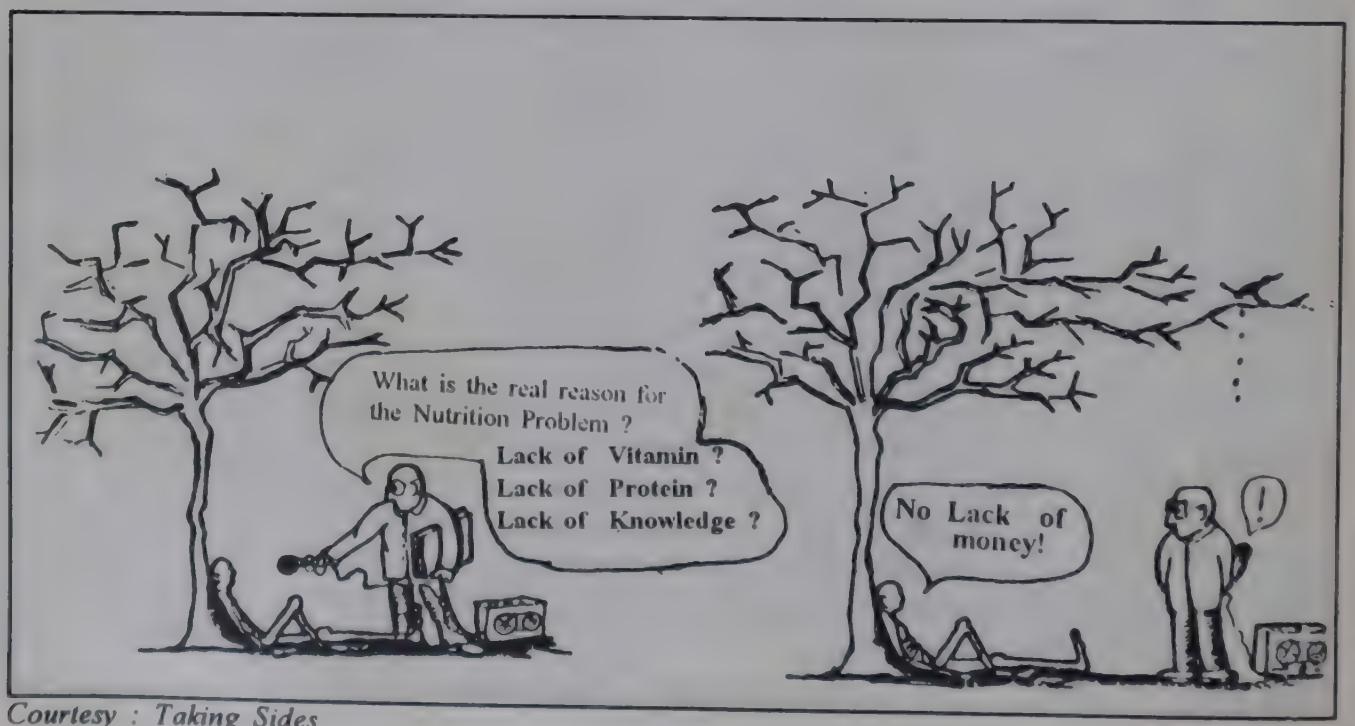
Food Consumption

Percentage share of total household consumption (1980/85)

Country	Food
India	52
Bangladesh	59
Srilanka	43
Pakistan	37
China	61
Costa Rica	33
U.K	12
U.S.A	10
FRG	12

Source: World Development Report, 1993

The adjustment process in the health sector clearly demonstrates a direction towards disaster, the price of which will be paid by the poor. The major challenge before the people is to resist the unhealthy trend. ■



Courtesy : Taking Sides

Publications on the eve of 50th Anniversary of the World Bank-IMF

THE WORLD BANK AND INDIA

Not long ago, it was fashionable to talk of the Public Sector capturing the commanding heights of Indian Economy. Now we have the World Bank, along with the IMF, capturing the commanding heights of Indian Economy. The World Bank is no longer involve in a single project as in the past (such as Singrauli and Sardar Sarovar Project). The Bank is managing the entire macro economy of the country. It approves Indian budget, monetary, trade, food, labour and fiscal policies.

Looking at the growing hold of the World Bank on Indian Economy, we are bringing out an activist handbook to examine the relationship between the Bank and Indian government. Written in a popular style and language with cartoons and photos, this handbook will act as a tool of mobilisation against the World Bank's policies in India. It includes chapters on :

- **The World Bank**
- **The Bank-India Relations**
- **The Bank and Singrauli Project**
- **The Bank and B.P.D. Project**
- **The Bank and Agriculture Sector**
- **The Bank and Energy Sector**
- **The Bank and Forestry**
- **Campaign: the Bank and SSP**
- **The Bank and the Poor**
- **The Bank and Population Problem**
- **The Bank and SAP**
- **The Bank and NGOs**
- **The Bank and Good 'Governance'**
- **Campaigns**
- **Resources**
- **List of Bank funded projects in India**

Pages: **88** ***Price*** **: Rs 30 / $5**

[The Hindi and Tamil language editions under preparation]

THE PRICE OF POWER

This is the report of a fact-finding team to Singrauli to examine the adverse social and environmental impacts of large-scale power and mining projects funded by the World Bank and other agencies. The fact-finding team consisted to representatives of various NGOs and people's movements in India as well as abroad.

[The Hindi and Tamil language editions under preparation] ***Price : Rs 10***

FORTHCOMING

POPULAR BOOKLET ON SINGRAULI

A popular booklet looking into various issues related to power and mining projects in Singrauli. It critically examines the role of the World Bank in funding socially and ecolgically disastrous projects in Singrauli.

[To be released in October 1994]

FORTHCOMING

THE IMF AND INDIA

After the publication of the World Bank and India, this is the second activist handbook to examine the role of IMF in guiding India's economic policies especially since the 1981 loan from the IMF. Written in a popular style and language with cartoons and photographs, this handbook will strengthen the ongoing campaign in India against the policies of IMF, especially on the eve of its 50th anniversary. The handbook includes chapter on

- **What is IMF ?**
- **What is SDRs ?**
- **Types of IMF loans**
- **1981 loan from IMF**
- **1991 loan from IMF**
- **Campaigns Against IMF**
- **Resources**
- **IMF Policies in Third World**
- **And Marry Morse....**
- **List of IMF loans to India**
- **History of Fund-India Relationships**

[To be released in November 1994]

PAMPHLET ON BWIs

A popular pamphlet on the World Bank and the IMF for mass distribution in India and other South Asian Countries. We are planning to print 1,00,000 copies. This will be reprinted in many languages in India and other Asian countries on the eve of the 50th anniversary.

Language: English and Hindi ***Price : Rs 1 each***

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A Critical Evaluation

This is a research study to critically evaluate the impacts of the first phase of structural adjustment programme in India from 1991 to 1994. In this study, we have looked into lthe perfomance of various economic parameters during three years. An important sections of this study is the compilation and analysis of people's response to structural adjustment programme in India during 1991-94. The information for this section has been provided by hundreds of NGOs, people's movements, unions and political groups in India who have carried out various activities against the adjustment programmes and provided various alternatives to deal with the economic crisis of 1991.

[To be released in September 1994]

PEPSI IN INDIA

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